

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025926

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6926

STATE FILE NUMBER

FILED JUL 12 1963

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, give TOWNSHIP only)
OR TOWN

St. Louis

Length of stay in 1b

9 months

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION

St. John's

Inside Limits
Yes ☒ No ☐2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

Illinois

Madison

c. CITY
OR TOWN

Collinsville

Inside Limits
Yes ☒ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm
Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

DAVID

Middle

JOSEPH

Last

GUINZY

4. DATE
OF DEATH

Month

Day

Year

7

1

1963

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☐ Never Married ☒
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

4-12-46

9. AGE (last birthday)

17

IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

High School

11. BIRTHPLACE (City and state or country)

East St. Louis, Ill.

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

John Guinzy

13b. MOTHER'S MAIDEN NAME

Mary Truccano

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

John Guinzy

410 Vandalia St.
Collinsville, Ill.18. CAUSE OF DEATH (Enter only one cause per
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

Pneumonia - Relapsed
Critical Nervous System Disease - type unknown
355xINTERVAL BETWEEN
ONSET AND DEATH
12 hours
10 monthsPART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: but not related to the terminal
disease condition given in PART I (a)PART III. If deceased was female was
there a pregnancy in last 90 days.☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT SUICIDE HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURYHour a.m.
p.m. Month, Day, Year20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 9/27/62 to 7/1/63 and last saw him alive on 6/30/63
Death occurred at 11:00 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Deceased or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Burial 7-4-63

SS. Peter & Paul

Collinsville Ill.

JUL 2 1963

Road Smith M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by Not Embalmed Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert C. Hays

Licensed Embalmer No. 2803

P. O. Address Collinsville, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.